Voyage 1 Limited

73 High Road

Inspection report

Gorefield
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Ratings

Overall rating for this service	Good

Is the service safe?	Good
Is the service effective?	Good
Is the service caring?	Good
Is the service responsive?	Good
Is the service well-led?	Good

Summary of findings

Overall summary

73 High Road is registered to provide accommodation for persons who require nursing or personal care for up to six people. At the time of our inspection there were five people using the service. The service is located in the village of Gorefield near Wisbech town.

In addition the service also provides care to people who are accommodated in their own home. At the time of this inspection a service was being provided to three people.

This announced inspection took place on 21 September 2016.

The service had a registered manager. A registered manager is a person who has registered with the Care Quality Commission (CQC) to manage the service. Like registered providers, they are 'registered persons'. Registered persons have legal responsibility for meeting the requirements in the Health and Social Care Act 2008 and associated Regulations about how the service is run.

Staff, as a result of training and support they had received, possessed a good practical knowledge of recognising the signs of, and protecting people from harm.

Risk assessments had been completed, were detailed and recorded how each person's risk were managed as safely as practicable. This was planned to help staff manage any potential risks such as those for people who could exhibit behaviours which could challenge others.

A sufficient number of skilled, safely recruited and competent staff were in post.

Staff had been trained and deemed competent in the safe administration of people's medicines. Medicines were safely administered. Staff administered people's medicines safely including medicines prescribed to be given 'when required'. However, the recording of people's medicines was not accurate. This meant that there was a risk that the management of medicines was not as safe as it should have been.

Staff were provided with training deemed mandatory by the provider as well as subject specific training according to people's needs. An effective induction, supervision and mentoring process was in place to support staff in a positive way.

Systems were in place to support people in the event of an emergency such as the need to evacuate the premises.

The CQC is required by law to monitor the operation of the Mental Capacity Act 2005 (MCA) and Deprivation of Liberty Safeguards (DoLS) and to report on what we find. The service's manager, team leaders and care staff were knowledgeable about if and when a decision needed to be made that were in people's best interests.

People were supported by, and they had to access to, those health care professionals and services that they required. People were encouraged and supported to have a healthy balanced diet and adequate hydration according to their needs.

People experienced care that was dignified and compassionate. Staff put people's needs first and foremost. Advocacy arrangements were used to support those people who had need of this support.

People were involved as much as practicable in developing and reviewing their care plans. Information contained in each person's care plan was detailed and up to date. Staff respected people's preferences and individual circumstances. People were supported with various opportunities to be as independent as practicable with a wide range of hobbies and interests.

People, their relatives and staff had access to a complaints process which was provided in an accessible format. People and staff were encouraged to provide their views on the quality of the service and the care that it provided.

People were provided with various opportunities to contribute to the running of the service. This included various meetings for people, staff and management. Audits that were undertaken were effective in driving improvements.

The registered manager had fostered and supported an open and honest staff team culture. Lessons were identified and learned from any accidents and incidents and these had been used as opportunities in making changes to the benefit of people. People could and did access the local community at every available opportunity.

The five questions we ask about services and what we found

We always ask the following five questions of services.

Is the service safe?

Good

People were safely supported with the administration of their prescribed medicines. However, the recording of people's medicines was not accurate. This meant that there was a risk that the management of medicines was not as safe as it should have been.

Staff possessed a working and practical knowledgeable about how to protect people from harm. Staff followed the provider's reporting process should any incident of harm occur. This helped people to be safe.

People were supported with their needs by a sufficient number of safely recruited, qualified and competent staff.

Is the service effective?

Good

The service was effective.

Staff had the skills and knowledge they required to meet people's needs.

People were supported and encouraged to make decisions about their care and how they lived their lives.

People were supported to access health care services and their nutritional needs were met.

Is the service caring?

Good

The service was caring.

People were encouraged to be as independent as they wanted to be.

People were cared for compassionately by staff who respected people's rights, independence and how each person communicated.

People could use the support of an advocate if they preferred or needed this.

Is the service responsive?

Good

The service was responsive.

People contributed to the identification and implementation of their care and support needs.

People were given and took many opportunities to follow their chosen hobbies, interest and educational courses. This contributed to people's daily living skills and independence.

People were provided with inclusive methods to gain their views and concerns. Prompt and effective actions were taken if complaints were raised.

Is the service well-led?

Good

The service was well-led.

Inclusive methods were used to listen to and involve people in making improvements to the way that the service was run.

The registered manager had developed and fostered an open and honest staff team culture.

A range of staff support mechanisms and quality assurance audits were in place. These were used to help ensure that the appropriate checks and balances to safely support people including the right staff with the right skills were in place.

73 High Road

Detailed findings

Background to this inspection

We carried out this inspection under Section 60 of the Health and Social Care Act 2008 as part of our regulatory functions. This inspection was planned to check whether the provider is meeting the legal requirements and regulations associated with the Health and Social Care Act 2008, to look at the overall quality of the service, and to provide a rating for the service under the Care Act 2014.

This announced inspection took place on 21 September 2016 and was undertaken by one inspector. We gave the provider 24 hours' notice as some people had anxieties which could be triggered by visitors they were not aware of.

Before the inspection, the provider completed a Provider Information Return (PIR). This is a form that asks the provider to give some key information about the service, what the service does well and improvements they plan to make. We looked at this and information we hold about the service. Before the inspection we looked at the number and type of notifications submitted to the Care Quality Commission. A notification is information about important events which the provider is required to tell us about by law.

During the inspection we spoke with two relatives by telephone, the registered manager, one senior and three care staff, and a visiting maintenance person from the provider.

We observed people's care to assist us in understanding the quality of care people received. This was because people did not communicate with us in a verbal way.

We looked at three people's care records, the minutes of managers' and staff meetings. We also looked at medicine administration and management records. This was as well as records in relation to the management of the service such as records of equipment that had been regularly serviced. We also looked at staff recruitment, supervision and appraisal process records, training records, complaints and quality assurance records.

Good

Is the service safe?

Our findings

People were protected from harm as much as practicable. This was by staff who had been trained and were knowledgeable about recognising, reporting and taking action should any harm be identified. All staff we spoke with were able to tell us the signs and symptoms of people should the person be concerned about their safety. A relative told us that staff always turned up on time and stayed until all the care was completed. One staff member said, "If people are withdrawn, quiet, not communicating with us as they would normally I would investigate why this was and report to the [registered] manager." We observed how staff assisted people with their moving and handling in a gentle and sensitive manner. We also saw how safeguards were in place to ensure people drank the right quantities of liquids and ate foods that were of the right consistency such as fork mashable or no larger than a specific size. One staff member said, "If identified any type of [harm] I would report to the [registered] manager and if they were the abuser I would call head office, the CQC or the local authority. We have the numbers in the office if we need them." A maintenance engineer told us, "They [staff] don't let me in until they have checked and validated my identity."

We saw that information in an accessible format was provided to people so that they could raise any concerns about their safety. For example, people could communicate to staff by using sign language, picture cards or objects of reference. The provider told us in their PIR that, "All staff receive safeguarding training upon induction, and this is also discussed during supervisions. Staff work in line with all support guidelines and risk assessments at all times." We found during our inspection that this was the case. Another staff member told us about their training on protecting people from harm and that, "I know that people who can't express their concerns in a verbal way need us to support them and make sure they are as safely cared for as possible. I would expect the same myself." This showed us that the service and its staff considered people's safety and that they would act on any concerns if required.

The registered manager explained to us how all staff had undertaken none physical intervention training. This included de-escalation techniques that were used to reduce the potential for any escalation in people's behaviours that could challenge others. For example, by staff withdrawing from the person's room or the situation. One staff member said, "Sometimes [name of person] can exhibit [type of] behaviours. I immediately tell them that their actions are not acceptable and leave them for a few moments. We have to be mindful of the same situations when out in the community. It's our job to keep people and staff safe." We observed how staff effectively implemented the training they had received to help ensure people were protected from harm.

Up to date records, risk assessments and strategies were in place for the management of risks to people. This included, whilst out in the community, moving and handling, medicines administration and for people's eating and drinking. Reviews of risk assessments had been completed and various changes had been implemented according to the risks to the person. Changes included reviews of people's medicines if a person's health condition had improved. A senior care staff told us, "We need to make sure, for people who need boundaries that we stick to these such as not letting people get into a situation which could cause them anxiety." They told us that this helped the person understand any potential consequences of their actions.

Each person had a personal evacuation plan in place that had been tailored to the safety of the person. This plan included the support arrangements to help assure the person of their safety should they need to be evacuated in an emergency situation such as a loss of utility power supplies or a fire. Other information was available if people needed to be urgently admitted to hospital. This information included guidance for hospital staff on the situations which could cause a person anxieties and the calming or prevention strategies that needed to be adhered to.

A comprehensive system was in place for the identification and management of accidents and incidents. The provider told us in their PIR, "All documentation regarding an incident with medication are kept within the service to ensure the service remains transparent and safe. Any staff involved in any medication incidents are required to attend medication error meetings, as well as incident forms being completed. Disciplinary meetings are carried out when required." We saw that the registered manager analysed incident records to identify any particular trends such the specific time or situation of any person experiencing a fall, seizure or other incident. Lessons had been learned from the analysis of these incidents. From records we viewed we saw how new procedures had been introduced to help ensure people took their medicines in a safe way.

Our observations of people's care and speaking with staff we found that there was sufficient staff to meet people's needs. One staff member told us that recently it had been a little bit more difficult [with staff levels] as there had quite a few sick absences. The registered manager told us that they were aware of this and actions were being taken through the provider's staff management procedures. This was as well as recruiting additional staff for planned staff absences. A senior care staff told us, "We [staff] do work well as a team; we cover additional shifts; we only use agency on the rare occasions where either myself or the [registered] manager can't cover the vacancy." This showed us that that there were systems in place to help ensure people were cared for in a safe way as much as practicable.

We found from records we looked at that staff had been recruited in such a way that only those staff who were deemed suitable were employed at the service. Various checks had been undertaken to ensure staff met the standards required by the provider. For example, checks including a Disclosure and Barring Service (DBS) check for any potential concerns that would prevent the staff from being employed. Other checks included at least two written references, qualifications, photographic identity and details of staff's previous employment history. One staff member told us, "When I started working here I had to bring in proof of my address, my qualifications and my driving licence. I wasn't allowed to start until my DBS came back [no issues recorded]."

Relatives told us that staff always made sure that their family member took or were administered their medicines and that staff recorded this on a medicines administration record (MAR). Staff were regularly trained and assessed as being competent in the safe administration of people's prescribed medicines. This included training for people who required support to take their medicines through a tube into their stomach. We noted that medicines were administered and stored safely. However, we found that where medicines had been used from the following 28 day's supply the recording of this was not accurate. For example, if medicines had been accidentally dropped or the person had refused to take them. Staff were able to tell us the reasons for this but had not always recorded this. The registered manager told us they would address this recording anomaly straight away and that staff would be reminded of their responsibilities.

We observed how staff checked that the person wanted their medicines, that they had a drink and that the person took their medicines correctly. Protocols were in place for homely remedies and also medicines that needed to be administered as and when required. A relative said, "They [staff] do all my [family member's]

medicines as they have them through their PEG (Percutaneous Endoscopic Gastrostomy)." This is a medical procedure in which people are fed an administered their prescribed medicines through a tube into their stomach. People were supported to be as independent as possible with their medicines.

Good

Is the service effective?

Our findings

People's assessed needs and preferences were met by staff who had the relevant experience, skills and knowledge. One relative told us, "They [staff] definitely know what they are doing. My [family member] needs hoisting and they [staff] are very professional doing this." Staff underwent a robust induction, ongoing staff development and mentoring. Staff also completed more specialist training according to the people's needs on subjects including autism, epilepsy and dementia. One staff member told us, "We have an [e-learning] system and we have to complete, safeguarding, health and safety, the MCA (Mental Capacity Act 2005) and DoLS (Deprivation of Liberty Safeguards) as well as doing hands on moving and handling."

Staff who had recently started working at the service told us that their induction included, shadow shifts (working with a more experienced staff member) until they felt confident. One staff said, "I had to do all my training and this was very comprehensive. I only worked with less support when I was satisfied and confident. I can ask for more help if there was ever anything that I was unsure about."

We found that a staff support and training programme was in place and that they had the skills and knowledge they required to meet people's needs. All staff we spoke with had been trained and had regular updates in those subjects that people required support with. For example, positive and proactive care which used non-physical interventions. This was to de-escalate situations in a non-physical way where people had behaviours which could challenge others. Several staff told us that they would benefit from some training about people with mental health support needs. The registered manager told us that this was something they would look into. Relatives we spoke with and the care we observed confirmed that staff considered people's health conditions in the way the person communicated. This was by using objects of reference such as a cup, Makaton [signs (gestures) and symbols used with speech] and sign language. All staff we spoke with told us that the training they received enabled them to do their job well. One staff member said, "I have had training on health and safety, infection prevention and control and food hygiene, fire safety and safeguarding people from harm." A relative told us, "Absolutely yes, they [staff] do know what they are doing. My [family member] would tell them if they didn't."

A planned programme of supervision was in place for all staff. One staff member told us, "It is much better now as we get a supervision. One staff member told us, "It is much better now as we get a supervision. The new [registered] manager has included us and makes sure we attend the service (at 73 High Road) for our refresher training." Staff told us and we found that they had an input into their supervisions and that they felt listened to. One staff member told us, "I can raise any points that weren't urgent and [name of registered manager] really does take on board what we say." The registered manager told us that their main priority had been to support staff to get the best out of them. We observed how staff's support had a positive impact on people. For example, where staff also undertook the same interests and hobbies as people such as football and swimming and as a result of shared interests helped build a relationship. This helped people be more confident and achieve their potential.

The MCA provides a legal framework for making particular decisions on behalf of people who may lack the mental capacity to do so for themselves. The Act requires that as far as possible people make their own

decisions and are helped to do so when needed. When they lack mental capacity to take particular decisions, any made on their behalf must be in their best interests and as least restrictive as possible. People can only be deprived of their liberty to receive care and treatment when this is in their best interests and legally authorised under the MCA. The registered manager with support from an operations director had ensured that appropriate requests for a DoLS to lawfully authorise people to be deprived of their liberty had been submitted.

We saw that for four people these were being progressed and one had been authorised. We did however find that the authorised DoLS and the subsequent restrictions had not been included in care plans. Staff told us what these restrictions were such, "as always accompanying people whenever they went out". The registered manager had included mental capacity assessments, best interest decisions and told us they would add the DoLS to people's care records straight away. We checked whether the service was working within the principles of the MCA. We found that all staff, due to their training on these subjects, understood what the five key principles of the MCA were and how to apply these. One staff member told us, "The MCA is all about respecting people's choices. We can't force people to do things but we need to keep them safe. If we need to put restrictions in place such as sensor mats or bed rails this must be the least restrictive option."

One staff member said, "Giving people options such as meal choices, holding up a choice of clothes or making various suggestions helps them to decide." This showed us that any assistance to help people make decisions were in line with the MCA and DoLS codes of practice.

We found from speaking with relatives, the records we viewed and the staff we spoke with that people could choose their meals. This was by going shopping to buy food that was healthy, of the right consistency and suitable for the person's health conditions. Other ways people received adequate nutrition and hydration was by PEG feeding. One staff member said, "[Name] likes certain foods but we guide them on what they can eat for their [health condition]." As well as a Sunday roast people could have a choice of meals. Staff used innovative ways to include healthy eating options such as vegetables with chicken. This was for those people who needed support with their decision making.

We found that where required a speech and language therapist and dietician had been involved with people's care. For example, for those people at risk of choking or maintaining a healthy weight. We saw that there was always an alternative option such as a take away if people changed their minds and where this was safe. We asked one person if they were enjoying their meal. The response was a smile and a thumbs up.

We found that people's health care needs had been met with a variety of support. This was from the appropriate health care professionals such as a GP, optician or dentist. The provider told us in their PIR, "Speech and language therapists and occupational therapists along with other [health care professionals] are consulted when required. Their guidance is always followed to ensure we support [people] in the manner which promotes as much choice and independence as possible." We found that people were supported with all their health care needs including well man/woman clinics. This was to help ensure that any risks associated with people's health were minimised. For example with nutritional related health care needs with PEG feeding. We saw that the advice, guidance and instruction from health care professionals had been followed such as people's nutritional support. People could be assured that their health and nutritional needs would be safely met.

Good

Is the service caring?

Our findings

People's relatives we spoke with were complimentary about the care that their family members received. One relative said, "They [staff] are very kind. If they weren't my [family member] would tell them in their own way. To tell you the truth, we have never had any problems with the (personal) care. They [staff] really do care. They would crawl over broken glass just to make sure they got to see my [family member]." We observed how one person gave staff a 'thumbs up' when asked if they were enjoying their favourite TV programme. We saw several other occasions where staff sought assurance as to people's wellbeing such as, "did you have a good night's sleep", and "would you like more tea?" which were acknowledged with positive responses.

Staff were able to describe the various ways they used to help ensure people's dignity and privacy was respected. One staff member told us, "I make sure the curtains are closed, that all the clothes and towels are in place. If their [person's] door is ajar. I still knock, check that the person is decent before going in and introducing myself." Another staff member told us, "I wouldn't do this job if I didn't care for them [people]. We are here to do the things they can't but we make sure we respect their independent skills no matter if these appear small." Relatives we spoke with and our observations confirmed that this is what happened. One said, "They [staff] are always talking with my [family member]. This keeps them relaxed."

We heard staff addressing people by their preferred name and also showing respect for the person's dignity. For example, by being discreet in the way they supported people with their personal appearance. One relative told us, "Everything they [staff] do is for my [family member]. I wasn't so well the other day and they made sure I was alright as well. I can't fault them with anything. They are all nice and kind." We also observed how staff helped people to dress appropriately for the weather conditions. We heard staff asking a person, "Would you like me to get you a cooler jacket?" This was because the weather had warmed up. We also observed several other occasions where staff showed a genuine concern for people's wellbeing such as eating and drinking and attending to people's subsequent needs in private. People could be assured that they would be cared for in a dignified and respectful manner.

People's care plans were detailed and contained as much relevant information that could practicably be obtained. For example, people's life histories, preferences for the gender of staff, communication skills, having a bath or shower as well as the pastimes that each person preferred to do each day. Care plans identified and guided staff about the care that worked well for each person. This was as well as detailing those staff who shared similar hobbies and interests such as playing/watching football, different types of music, cooking and having a respectful laugh and joke. One relative said, "My [family member] gets on well with the girls [staff]. Yes, they do have a laugh as my [family member] has a great sense of humour which they [staff] share."

Staff were mindful of the security of people's confidential information and they made sure that any personal records were only reviewed or read in private. Our observations showed us that staff understood people's needs and how best to meet these. For example, with Makaton, listening to what people communicated with their facial expressions, vocalisations and sign language. We observed that the care provided was done

in a calm and unhurried way. For example, by respecting the time people wanted or needed to eat their meals. The registered manager told us and we saw that one person did not want to get up at their usual time. The registered manager investigated this situation and later in the day the person had been assisted to get up when they felt better. This showed us that staff responded to people's distress or discomfort. We saw how staff used their communication skills in their understanding of what the person was telling them such as wanting a drink or some other assistance.

The staff made sure people felt that they were listened to using the various ways people expressed their views. This included behaviours which could challenge others. One staff member told us, "I know straight away if there is something that the person is upset or uncomfortable about. They use their [preferred means of] communication and generally I can help them to become calm quite quickly, by giving them time or just stepping back a bit." We saw that staff used clear boundaries to encourage people such as a firm but kind manner as well as using an appropriate tone in their voice.

One relative to us that staff knew their family member well. They said that this was because, "They [staff] have known us for [several] years and we know when they arrive with their cheery voice and asking if we are both well. It's my [family member] who has the care but I am included in that as well. Everything they do, they do it well. They are all brilliant in the way they provide care."

We found that people could have their parents or social worker to act as their representative if this was the person's choice. Where people had no surviving relatives we saw that they were supported with an independent advocate. Advocacy is for people who cannot always speak up for themselves and helps ensure that the views of the person were acted upon. Other advocacy support had also been provided through people's assigned social worker. This was to help make sure that care was in the person's best interests. All management and staff were aware of when advocacy was required. This showed us that people's wishes, needs and preferences would be respected if people were not able to speak up for themselves.

Good

Is the service responsive?

Our findings

People's assessed needs were determined prior to, and during, their use of the service that was to be provided. This was planned to help ensure that the registered manager and their staff were able to safely meet the person's needs and preferences in an individualised manner. Other information, including that from the person, their relatives or any previous placements was also used. This was to help promote people's strengths and those aspects of people's lives that were important to them. One relative told us, "My [family member] loves to chat about the football and compare their team to the staff's." Staff described to us in detail what each person's preferences were and their levels of independence. We observed how people were involved in preparing meals and drinks with limited, or as much, support as required. Staff respected people's abilities and this helped people maintain or increase their independence.

A key worker was in place for each person. This is a member of staff who had the responsibility for certain aspects or details of people's care. The input of information from all staff was coordinated by the key worker. This was to help ensure that each person's care was as up to date and as relevant as possible.

Relatives we spoke with told us that they were involved in providing information about their family member as part of each person's individual care. This was to help ensure people's needs were met in a way that the person wanted and benefitted from. We found people were supported and encouraged to be, and live, by staff as independently as possible. Encouragement to undertake daily living skills by staff included people helping to safely empty the dishwasher. We saw how staff understood people's requests and choices. This was by supporting people with established boundaries such as allowing people to make choices but doing this in a way which benefitted the person. For example, where people had behaviours which could challenge others, staff used strategies and techniques which avoided those situations which could cause distress.

We found that a wide range of social stimulation had been provided. Various records we viewed, and information staff gave us confirmed that these opportunities had been undertaken. People had programmes in place for activities such as work, education, hobbies and interests. The registered manager told us and the operations' manager and staff confirmed to us how one person whose ambition to do a dangerous sport had been supported. As a result of the person not being able, due to unforeseen circumstances, to do the jump the operations' manager had stood in and done this for them. The person had been able to watch and celebrate the event at an after party involving staff, relatives and friends. Other social activities that were completed included, bowling, horse and cart rides, going to a zoo, farm or the seaside, being visited by a provider of Pets As Therapy (PAT) which included reptiles and farm animals. People were also supported with technology in various ways that included speaking clocks, flashing light door bells and adapted moving and handling equipment for any impairment. A relative told us, "My [family member] goes to work and they [staff] make sure they are ready and on time." As a result of staff's interventions this had enabled people to live a meaningful and rewarding life.

Other ways staff supported people with their interests was by assistance to play their favourite electronic game and including options for dancing. Access to the community was provided using the service's transport. This transport was used to convey people to various activities of daily living such as going to a

disco, coffee morning, bowling, bingo and swimming. One relative told us, "I am not getting any younger and knowing that my [family member] gets to do what [they] want to means a lot." This showed us that people were supported to be independent and lead the lives they wanted.

People's care plans were in a format that made them accessible such as easy read or pictorial format. In conjunction with the person or their relative/advocate, reviews of the care that was planned and provided were completed at least annually but also more urgently if the need arose. For example, changes to a person's bedroom flooring to assist with their dignity and moving and handling. People were effectively supported in various proactive ways to make informed choices about their preferences. These included choices of clothing, pastimes, as well as the time and place they liked to eat. The complexities of people's care were reflected in the level of detailed guidance in people's up to date care plans. For example, how to respond to each person such as the amount of assistance, care and support that was needed to meet the person's individual circumstances.

As well as the day to day contact with staff. People had regular meetings where they could make suggestions and express any concerns. This was as well as being involved as much as reasonably practicable in developing their care and support plans. A range of communication strategies were used to help ensure that each person's wellbeing was maximised. For example, by using Makaton, objects of reference and other non-verbal means such as people giving a thumbs up or down depending on their response to the questions asked. This helped staff to determine the aspects of people's care that worked well and where any changes were required. This showed us that the provider considered people's views in as many ways as practicable.

We saw that people's concerns, complaints and suggestions had been used to drive improvements in the way that care was provided. Access to various different ways people could express their views were provided. For example, residents' meetings and staff's knowledge about each person they cared for. Since taking up their post in May 2016 the registered manager had reviewed all policies and procedures around complaints and the way they were responded to. We found that complaints had been investigated, acted upon and resolved as far as reasonably practicable to the satisfaction of the complainant. Where they did not have the power to deal with a complaint then the matter was escalated to the operations' director. One relative told us, "They [staff] keep in touch regularly and ask me if I have any complaints. I have never had to complain everything is perfect as it is." A staff member told us, "Generally, if people are upset about anything, they tell us in their own way. They show, point or tell us what the problem is. Sometimes we use a different member of staff such as one who shares the person's sense of humour to get all the information we need."

Good

Is the service well-led?

Our findings

The service had a registered manager. They had been in post since May 2016 and had prioritised the improvements to the service that were needed. This had been in developing, nurturing and then maintaining an open and honest staff culture. They were supported by an operations' manager, senior care staff, care staff and various maintenance staff. The support they had been provided with had enabled them to do their job to the expected standards.

The registered manager said, "When I started I found that (due to their experience) there were many changes required. I started with the staff team as previously, staff working in the community had been left to their own devices." One care staff told us, "It (the support) has been so much better with the new [registered] manager in place. I never used to have regular supervisions, meetings or visits from them. It's so much better now as I feel included in everything." A senior care staff said, "I feel it is my time at the one to one with my [registered] manager. We discuss what's working well and where anything could be done differently such as, I have tried this or I am going to try this. For example, supporting people with their continence and seeking prompt advice from the community nurse." From information we hold and our findings at this inspection we found that the registered manager was aware of their responsibilities. This included the appropriate notifications that they had been required to send to us.

People, staff members' and management views about improving the service were sought as frequently as required. This was as well as these views being sought from people in the most effective manner. This included people's body language, for acceptance/refusal of care, non-verbal comments with sign language and pointing to objects of reference. Staff told us that when relatives came to pick up their family member for holidays and weekends their opinions and views were also sought. This was to help identify and implement any potential for improving the quality of care that was provided.

The provider had recently undertaken a quality assurance survey questionnaire. The results of this had not yet been analysed as this survey had just been finalised. The registered manager told us that there had at first glance not been any surprises but any improvement or potential for this would be acted upon. One relative told us, "I have an appointment booked with the [registered] manager but I haven't any issues. All the care is just as I would expect. It's my [family member but I [speak up] for them." Another relative said, "They [registered manager] came out a couple of months ago and checked with us that everything was as we wanted. Apart from meeting them, which we had not [been offered the opportunity] in the past, we had no issues with anything." Both relatives told us that they now really felt listened to and one relative added that the new registered manager was a "breath of fresh air".

All staff and relatives we spoke with told us that the registered manager and if required, operations' manager were very approachable. One senior care staff told us, "It is so much better now. [Name of registered manager] is a hands' on manager. They sometimes observe our working practices and you don't know they are doing it as they work with you." Staff confirmed that this helped them develop their skills in a proactive manner and that as a result, the teamwork culture had improved. During our discussions with the registered manager it was clear how well they knew each person and all staff. For example, by knowing the

most successful means of communication whether this be at a meeting, day to day conversation as well as formal procedures. This was for the occasions where staff did not maintain the required standards of care that were expected of them. This standard was set in the provider's values of how staff needed to conduct themselves. Our observations, records we looked at and communications from people showed us that staff upheld these values. One staff member told us, "I very much enjoy working here. I would have a family member live here. Staff do things to the best of their ability and everything they do as fully as they can for people."

Many links were maintained with the local community and included but were not limited to visiting a zoo, going to the cinema or arts class. Other links included access to social media and various methods of video communications.

All staff were very appreciative and complimentary about the support that they now received on a daily basis. This included a regular staff supervision, team meetings as well as being mentored and guided by more experienced staff and management. All staff commented how much more valued they felt and that they could put forward their views and opinions and that these were acted upon. This helped them to be confident of being able to deliver people's care to the required standards. One staff member said, "They [registered manager] definitely has their door open and not just physically. I can speak to them in confidence at any time. I have their mobile number if there is ever any situation I am not sure about." We observed that the care that people received and the access that was provided to the community, improved the quality of people's lives.

We found that there was a variety of effective audit and quality assurance processes in place. This was in the form of spot checks, staff supervision and appraisals as well as managers' meetings. Any good practice identified at the managers' meetings was then introduced across the provider's other similar services. For example, audits based on the methodology used by the CQC to help identify if the service was safe, effective, caring, responsive or well-led. However, we did find that the audits of people's medicines were not as effective as they should have been. Other audits included infection prevention and control, food hygiene and care plan risk assessments. Any actions required had been allocated to a staff member whose responsibilities included resolving the matter in a timely manner.

The registered manager had a clear understanding about the key challenges in running and managing the service. For example, in further developing the staff team culture, maintaining the right skilled staffing levels so that people could be truly independent and go out when they wanted to. One staff member told us, "There has been some increase in staff sick absences recently but [name of registered manager] doesn't put up with this if the staff can't provide a valid reason for their sickness." The registered manager told us that, if required, they could request to borrow staff from another of the provider's services. This was for staff who possessed similar care and support skills. Our findings at this inspection confirmed that the correct governance arrangements for the management and deployment of staff were in place.

At the daily handover meeting a diary was used to help staff to share and be aware of people's changing or new care needs. This included events such as changes to prescribed medicines, hospital visits or new strategies to support people with their communication skills. Updates to people's care and care provisions were audited. This was planned to help ensure that records were accurate and that people gained the most benefit they could from the improvements. This helped identify any further potential for improvement.